Local Case ID (Medical Record #): _____ **PHLIS ID Number**_____-_____-_____-_____
Isolated Parasite _____

Patient's name:_____
Last First

Address_____ **Phone No**: ( ) _____ - _____
Number/ Street City State ZIP

Foodborne Diseases Active Surveillance Network (FoodNet) Case Report Form

PHLIS ID # (Patient-Specimen): ❑❑❑❑ ❑❑❑❑ ~ ❑❑❑❑❑❑❑❑❑ ~ ❑❑❑ ~ ❑❑

Local ID _____ ~ ❑❑❑❑

1) COUNTY
(residence of patient):

_____
_____

2) SEX:
❑ Male ❑ Female ❑ Unknown

3) DATE OF BIRTH:
_____/_____/_____
month day year

4) RACE : (original categories)
❑ **White**
❑ **Black**
❑ **American Indian/ Native Alaskan**
❑ **Unknown**
❑ **Asian or Pacific Islander**

4a) RACE : (additional FN categories)
❑ Asian
❑ Pacific Islander or Native Hawaiian
❑ Multi-racial
❑ Other

5) ETHNICITY:
❑ Hispanic
❑ Non-Hispanic
❑ Unknown

6) SPECIMEN COLLECTION DATE
_____/_____/ 200____
month day

7) AGE:_____
years

8) IF < 1 YEAR, AGE: _____
months

9) SUBMITTING LAB:
_____
_____
Laboratory

9a) SUBMITTING PHYSICIAN:
_____
Phone: ( ) _____ -_____

Informant _____ **Date Report Received in Lab** _____/_____/ 200____
month day

10) SOURCE OF SPECIMEN: ❑ Stool ❑ GI Aspirate ❑ Small Bowel Biopsy ❑ Unknown ❑ Other site (specify):_____

11) ISOLATED PARASITIC ORGANISM:

❑ ***Cryptosporidium***

How identified? (Please check all that apply):

- ❑ Wet mount, not stained
- ❑ Wet mount, temporary stain, type: _____
- ❑ Acid fast, type: _____
- ❑ FA (Direct immunofluorescence)
- ❑ ELISA, specify immunoassay method:_____
- ❑ PCR
- ❑ Other, please specify:_____

❑ ***Cyclospora***

How identified? (Please check all that apply):

- ❑ Wet mount, not stained
- ❑ Wet mount, temporary stain, type: _____
- ❑ Wet mount, autofluorescence
- ❑ Acid fast, type: _____
- ❑ Safranin, type: _____
- ❑ PCR
- ❑ Other, please specify:_____

Data Entry: ☐ PHLIS
☐ CASE-CONTROL STUDY
☐ EPI INFO

A. Hospital Follow-up:

13) PATIENT STATUS AT THE TIME OF SPECIMEN COLLECTION:

❒ Hospitalized (*go to 15*) ❒ Unknown (*go to 15c*)

❒ Outpatient (*go to 14*)

13a) OISD (Other immunosuppressive diseases):

❒ Yes ❒ No ❒ Not available

---

14) IF OUTPATIENT, WAS THE PATIENT SUBSEQUENTLY HOSPITALIZED?

❒ Yes (*go to15*) ❒ No (*go to 15c*) ❒ Unknown (*go to 15c*)

B. Health Department Follow-up:

If the isolate was further characterized by the State Lab, please update #11.

17) DID THE STATE LAB RECEIVE THE ISOLATE?

❒ Yes ❒ No ❒ Unknown

17a) If Yes, STATE LAB ISOLATE ID NUMBER:

_____

---

18) WAS CASE FOUND DURING AN AUDIT?

❒ Yes ❒ No ❒ Unknown

---

19) WAS CASE ENROLLED IN THE CASE-CONTROL STUDY?

❒ Yes ❒ No ❒ Unknown

If No, Reason: _____

Reason Code: _____

---

20) IF AVAILABLE, PLEASE INDICATE:

Date of illness onset: ____ /_____ / 200___ ❒ Not Available
month day

Date of diarrhea onset: ____ /_____ / 200__ ❒ Not Available
month day

---

15) IF PATIENT WAS HOSPITALIZED
(that is, if answered "Hospitalized" to #13 or "Yes" to #14):

Hospital name:_____

Date of admission: _____ /_____ / 200___
month day

Date of discharge: _____ /_____ / 200___
month day

15a) TRANSFERRED TO ANOTHER HOSPITAL?

❒ Yes ❒ No ❒ Unknown

15b) If Yes, TRANSFER HOSPITAL NAME:

_____

15c) HOW WAS THE INFORMATION (from #13,14, or 15) DETERMINED?

❒ Patient / relative contacted

❒ Physician contacted or chart review / medical records review

❒ Did not follow up

❒ County provided information

---

16) OUTCOME: ❒ Alive ❒ Dead ❒ Unknown

16a) HOW WAS THIS INFORMATION (from #16) DETERMINED?

❒ Patient / relative contacted

❒ Physician contacted or chart review / medical records review

❒ Did not follow up

❒ County provided information

---

21) IS CASE REPORT COMPLETE? ❒ Yes ❒ No

21a) If Yes, DATE CASE REPORT COMPLETED:

_____ /_____ / 200____
month day

21b) INITIALS OF PERSON COMPLETING CASE REPORT: _____

Comments _____

_____

_____

Revised 01/22/2002